

NEW PATIENT HISTORY

To facilitate our getting to know you and provide you with comprehensive care, we would appreciate your cooperation in completing both sides of this form in regards to your health. Please complete by checking the appropriate box. If further explanation is necessary, please add comments where appropriate. When you meet with the clinician you may be asked for some detail regarding your responses to clarify issues. Thank you for your time and effort.

GENERAL INFORMATION:

NAME: _____ AGE: _____ MALE / FEMALE DATE: _____

HOW DID YOU HEAR OF OUR PRACTICE? _____

OTHER MEMBERS OF YOUR HOUSEHOLD:

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

REASON FOR YOUR VISIT TODAY: _____

ALLERGIES TO MEDICATIONS: _____

MEDICATIONS YOU TAKE CURRENTLY:

<u>NAME</u>	<u>DOSE (MG)</u>	<u># TIMES PER DAY</u>	<u>NAME</u>	<u>DOSE(MG)</u>	<u># TIMES PER DAY</u>
_____			_____		
_____			_____		
_____			_____		

PAST MEDICAL HISTORY: Check the box if you have had any of the following. Otherwise leave blank.

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's/Ulcerative Colitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Back/neck injury | <input type="checkbox"/> Other Mental Illness |
| <input type="checkbox"/> Blood Clots in Legs/lungs | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer: |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease | Type _____ |
| <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Head Injury | |
| <input type="checkbox"/> Other: _____ | | |

PAST SURGICAL HISTORY: Check the box and fill in the approximate date if you have had any of the following surgeries.

- | | | |
|--|---|---|
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Uterus _____ |
| <input type="checkbox"/> Hips _____ | <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Tonsils/Adenoids _____ |
| <input type="checkbox"/> Knees _____ | <input type="checkbox"/> C-section _____ | <input type="checkbox"/> Tubal Ligation _____ |
| <input type="checkbox"/> Ankles _____ | <input type="checkbox"/> Cervix _____ | <input type="checkbox"/> Vasectomy _____ |
| <input type="checkbox"/> Shoulders _____ | <input type="checkbox"/> Hernia _____ | <input type="checkbox"/> Skin Surgery _____ |
| <input type="checkbox"/> Other: _____ | | |

FAMILY HISTORY:

FATHER is living at _____ years old. Health Problems: _____

Deceased at _____ years old. Cause of Death: _____

Health problems on father's side of family: _____

MOTHER is living at _____ years old. Health Problems: _____

Deceased at _____ years old. Cause of Death: _____

Health problems on mother's side of family: _____

BROTHERS: How many? _____ Any medical problems: _____

SISTERS: How many? _____ Any medical problems: _____

SONS: How many? _____ Any medical problems: _____

DAUGHTERS: How many? _____ Any medical problems: _____

SOCIAL HISTORY

WHERE DO YOU WORK? _____ WHAT IS YOUR JOB TITLE? _____

HOBBIES/SPORTS/SPECIAL INTERESTS: _____

EXERCISE: YES / NO IF YES, WHAT KIND OF EXERCISE: _____ # OF DAYS PER WEEK: _____

DO YOU USE TOBACCO? YES / NO IF YES, HOW MUCH? ½, 1, 2, 3 PACKS PER DAY FOR HOW MANY YEARS? _____

DO YOU CONSUME ALCOHOL? YES / NO IF YES, WINE, BEER, HARD LIQUOR? HOW MUCH? _____ HOW OFTEN? _____

ANY HISTORY OF STREET DRUG USE? YES / NO IF YES, WHAT DRUG AND LAST TIME USED? _____

PREVENTATIVE HEALTH MAINTENANCE EXAMS

To the best of your knowledge, please provide the date with which you last had each of the following exams:

- | | |
|---|--|
| <input type="checkbox"/> Complete Physical Exam _____ | <input type="checkbox"/> Test for blood in stool _____ |
| <input type="checkbox"/> Pap Smear _____ | <input type="checkbox"/> Colonoscopy/Sigmoidoscopy _____ |
| <input type="checkbox"/> Breast Exam _____ | <input type="checkbox"/> Prostate Exam _____ |
| <input type="checkbox"/> Mammogram _____ | <input type="checkbox"/> Testicular Exam _____ |
| <input type="checkbox"/> EKG (heart tracing) _____ | <input type="checkbox"/> PSA (prostate specific antigen) _____ |
| <input type="checkbox"/> Chest X-Ray _____ | <input type="checkbox"/> Skin Exam _____ |
| <input type="checkbox"/> TB Test _____ | <input type="checkbox"/> DEXA (bone density) _____ |
| <input type="checkbox"/> Cholesterol Check _____ | |

IMMUNIZATIONS

To the best of your knowledge, please provide the date with which you last had each of the following vaccinations:

- | | |
|---|--|
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Hepatitis B _____ |
| <input type="checkbox"/> Flu _____ | <input type="checkbox"/> Haemophilus Influenza B _____ |
| <input type="checkbox"/> Tetanus/Diphtheria _____ | <input type="checkbox"/> Typhoid _____ |
| <input type="checkbox"/> Whooping cough (Pertussis) _____ | <input type="checkbox"/> Measles/Mumps/Rubella _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Shingles _____ |
| <input type="checkbox"/> Hepatitis A _____ | <input type="checkbox"/> HPV _____ |

Thank you very much for your time and effort in completing your medical record. Please sign and date below.

PATIENT'S SIGNATURE: _____ DATE COMPLETED: _____

PHYSICIAN'S SIGNATURE: _____ DATE REVIEWED: _____

